FTLife Claims Procedure – FAQ

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FTLife 富通保險

Claims Principles - FAQ

What is 'Utmost Good Faith" of an insurance contract?

- The term "Utmost Good Faith" means 最高誠信 in Chinese.

- The belief of Utmost Good Faith is a fundamental principle in insurance industry. In this sense, every person who enters into a contract with an insurer has a legal obligation to be honest and accurate to disclose his/her information.

- This principle serves as a foundation of the insurance contract which helps to ensure fair dealing between the insurer and the applicant/policyholder. If the applicant/ policyholder fails to meet his/her obligation, the insurer may void the policy issued.

What is meant by "Duty of Disclosure"?

- The applicant/policyholder (or the representative of the insured e.g. spouse, juvenile, etc.) has a duty to disclose all material information to the insurer at the time of insurance application.

When is duty to disclose required for insurance contract?

- "Duty to disclose" is a legal term that refers to the obligation of an applicant/ policyholder to provide all material information to the insurer. Such obligation is required under the following scenarios:-

  - New insurance application;
  - Reinstatement of a policy;
  - Addition of benefits to a policy;
  - Extension or change (increase) of benefit level or coverage;
  - During the policy period (If the previously non-disclosed information during the application is disclosed after the policy effective, the premium or policy terms may be adjusted accordingly)

What must be disclosed for an insurance contract?

- All material information or facts that are within applicant's/policyholder's knowledge or should be within his/her knowledge.

- If the applicant/policyholder is wondering whether the facts are material or not, these information should be disclosed.

What is "Misrepresentation"?

- "Misrepresentation" refers to any false, incorrect or misleading statements made by the applicant/policyholder to the insurer during his/her application.

- Misrepresentation can be intentional or unintentional. In either case, such information can have impact on the policy's coverage and benefits.

Examples:

  - failing to disclose a pre-existing medical condition
  - providing inaccurate information about smoking or alcohol consumption habits
  - misrepresenting the income or occupation

  - If the insurer discover that an applicant/policyholder made a material representation in his/her application and was being misled to come up to the underwriting decision, the insurer have the right to deny the claim and rescind the policy from inception.

What is 'material facts'?

- Material information/facts are any information that may influence the insurer's decision to offer insurance, the premium charged, or the terms and conditions of the policy.

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- A statement or fact is regarded as "material" if its presence or omission during the application process, would reasonably influence the judgement of an insurer towards any of the below decisions:
    - To decline or postpone to issue any policy
    - To issue the policy with exclusion(s) or alteration to the standard coverage
    - To issue the policy at a higher premium rate and/or with reduced benefits
    - To demand more medical tests or examinations during the underwriting process

- The following are examples of material facts:
    - health history of the insured: any known medical conditions including medical consultation or receiving treatment, hospitalization, surgery, prescription medication and/or suffering from specific symptoms
    - lifestyle habits: any addiction or habits such as smoking, drinking or drug abuse
    - employer history
    - financial status which affects financial underwriting process such as bankruptcy
    - insurance coverage with other insurers including any refusal of application or cancellation of insurance coverage for insurance
    - criminal history
    - moral hazards: engaging in dangerous activities such as extreme sports or risky hobbies

What is Fraud: Intentional Non-Disclosure or Misrepresentation?

- In insurance, intentional non-disclosure or misrepresentation refers to an applicant/ policyholder deliberately withholding or concealing information from the insurer during his/her application. Such action is considered as fraudulent misrepresentation.

- If an insurer discover fraudulent misrepresentation, they can decline paying a claim or rescind the policy from inception.

- Not only does fraud (i.e. intentional non-disclosure or misrepresentation) occur during the application process, it can also occur in claim process.

What is "Contestability Period"?

- The contestable period for a life insurance policy refers to a period of time, usually two years from the policy effective date. During the contestable period and the insured is alive, an insurer has the right to investigate the insured's medical history and other relevant information to determine if there was any inaccurate statements on the application. In other words, an insurer can contest a policy or a claim if there is evidence of material misrepresentation.

- After the contestable period, an insurer cannot contest the policy based on material misrepresentation, except for (1) fraud or (2) non-payment of premium.

- Any benefit items which are not subject to the Incontestability Clause (as specified in Policy Provisions), are always contestable. Depending on the product features, such Incontestability Clause is applicable to some Critical Illness products.

What is "Pre-existing condition"?

- A "pre-existing condition" refers to any health condition or illness that an insured has before an insurance policy effective.

Example 1: Depending on the plans purchased, a 'Pre-existing Condition' is the existence of:

- A condition of the insured for which medical advice, diagnosis, care or treatment is recommended or received before the effective date or the date of any reinstatement (whichever is later); or

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- Any sign or symptom within a five-year period immediately preceding the effective date or the date of any reinstatement (whichever is later) which would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment.

Example 2: For VHIS plans, Pre-existing condition shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where -

- it has been diagnosed;
- it has manifested clear and distinct signs or symptoms; or
- medical advice or treatment has been sought, recommended or received.

- Pre-existing conditions or illnesses is a common exclusion for claims related to medical/hospitalization benefits, disability benefits and critical illness benefits.

- The claim assessment concepts of applying the “Pre-existing” Clause and “Waiting Period” Clause (if applicable) are similar.

- The “pre-existing” or “Waiting Period” (if applicable) condition enable us to decline a claim. However, we cannot rescind the whole policy solely relying on this reason, unless there is material or fraudulent misrepresentation.

- Although pre-existing condition or “Waiting Period” (if applicable) does not enable us to rescind the whole policy, it is necessary to review and check for any cases with material misrepresentation/non-disclosure or fraud as they may closely related sometimes.

- Once the “pre-existing” or “Waiting Period” (if applicable) condition had been established and claim was denied, subsequent claims which is re-occurrence or related to that particular “pre-existing” or “Waiting Period” (if applicable) condition will be considered as invalid claims. We shall then decline all these claims for the reason of “Pre-existing” or “Waiting Period” (if applicable) condition. For VHIS medical plans, the “Waiting Period” Clause is not applicable.

What is “Unknown Pre-existing” Condition?

- “Unknown pre-existing” is a pre-existing condition for which the policyholder and/or insured was not aware and would not reasonably been aware of at the time of application submission, any updates of and changes to the required information.

- We have similar assessment philosophy towards both pre-existing condition and unknown pre-existing condition.

- For the VHIS plans, depending on the plan features, some contracts limit the benefits for “unknown pre-existing” conditions.

- Examples:

First Policy Year	No coverage
Second Policy Year	25% reimbursement
Third Policy Year	50% reimbursement
Fourth Policy Year onwards	Full coverage

What is “Waiting Period”?

- Usually for medical and critical illness products, and depending on the purchased plans, “Waiting Period” (if applicable) is a time period specified in the insurance contract for which no benefit is payable for events occurring in this period. The duration of such period varies according to the product design; 30 days or 60 days are commonly adopted by the insurers. It is widely used in medical/hospitalization benefits and critical illness benefits to avoid any early claims.

- Administration of the “30/60 days Clause” for non-VHIS products:
  - Any conditions/illness which exist before or at the effective date of the insurance policy, or occur during the 30 days (for medical/hospitalization benefits) or 60 days (critical illness benefits) following the effective date of the insurance policy, no cover will be provided.
  - Illness “occurring” means manifesting or symptoms appearing.
  - By using this “30/60 days” Clause to deny claims, it is not necessary that the insured must have consulted a doctor, or received a treatment or surgery, or been diagnosed of an illness with the 30/60 days period.

- We have similar assessment philosophy in the use of pre-existing clause and the “Waiting Period” clause.

- Once the pre-existing or “30/60 days” condition is established and claims denied, we shall decline all subsequent claims which is re-occurrence or related to that particular pre-existing or “Waiting Period” (if applicable) condition. For VHIS medical plans, the waiting period clause is not applicable.

What is “Symptoms” and “Signs”?

- Symptoms and signs of an illness are important clues for detecting pre-existing conditions (or occurring within the waiting period, if applicable) relevant to the submitted medical claims.

- “Symptom” is subjective experience such as pain, fatigue, itching or nausea while “Sign” is objective expression such as fever, rash or irregular heartbeat. The expressions of symptoms and signs could be overlapped. However, the distinction between symptoms and signs is that the former is usually experienced by the insured while the latter is observed by a medical professional who can rely on them to conclude a diagnose.

- To determine whether a condition/illness is pre-existing or falls into the “Waiting Period (if applicable)”, we should refer to the date when the symptoms or signs of such condition/illness exist, or first manifested. We have to trace the history of manifestation (i.e. the earliest point of time when the first symptom/sign got noticed by the insured).

Claimable Amount Estimation (CAE) and Pre-authorization (PA)

What is the TAT of the service? How do I receive the CAE result?

- Normally, the case result will be sent to the email written on the service request form in 5 working days. We recommended that the email address should be written in block letters and in clear manners to avoid mis delivery.

What is included in the result?

- Name of the insured, policy number, estimated medical expenses, estimated claimable amount and estimated out of pocket amount will be shown in the result letter.

How to submit the application?

- Currently, the only application channel is email to ftlhk.lifeclaims@ftlife.com.hk with subject includes "CAE application".

What is the benefit for applying CAE?

- CAE provide an estimation on how much can be claimed on single policy, helping client and agent to budget and plan for follow-up claims.

What is the difference for applying CAE via network doctor/ non-network doctor?

- In principle, the claims procedure remains the same for network doctor and non-network doctor. However, as we have agreed fee with panel doctor, most surgeries are within Reasonable and Customary, thus, we recommend client to consider using network doctor before commit to planned surgeries.

Is CAE suitable for urgent admission?

- No. CAE is designed for planned surgery that is not urgent, for urgent medical need to admit to hospital, we recommend not to apply CAE.

What is Pre-authorization service?

- Pre-authorization service is a pre-surgery/ pre-admission assessment by claims department, provide an assessment on the claimable amount and medically necessary based on the given medical information. For approved case, claims team will offer a Guarantee of Payment service with approved amount to the healthcare service provider (Day procedures centre/hospital) so that the client can focus on recovery and not to worry about the finance.

How to apply the service?

- Currently, there are 2 types of application, network doctor application/ non-network doctor application:
  1. Network Doctor:
     - Our network doctors have the PA service request form ready at their clinic/ centre, client need to show their medical card and state to the client staff their intention for "Pre-authorization" service.
     - After fill-in the service form, the network clinic to submit the application for you.

  2. Non-network doctor:
     - Please bring along the PA service request form to on your visit to your attending doctor. Then follow the instruction to email to FTLife.PA@ump.com.hk or fax to (852) 3468 2603.

What is the TAT of the service?

- Normally, the result will be sent to client in 4 working days after we received your application.

Do I need doctor to fill-in the form in order to use the service?

- Yes, the application required your attending doctor. There are some medical information requires your attending doctor to provide.

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Do I need medical card to use the service? How do I retrieve my medical card?

- Yes. Client need to show their eligible medical card to our network doctor to access the service. You can retrieve your medical card in "ReachFTLife" application; or you can ask your handling agent to retrieve the medical card for you. (Medical cards are always under policy level, not life insured level)

Can I apply the service without credit card?

- Normally, all Pre-authorization (PA) service require credit card in order to proceed the service application. Credit card details can be provided by relatives of the insured. However, we will consider waived the credit card requirement based on the surgery/admission type, estimated medical expenses, etc. For any enquiry during the application, please call our e-ConNET Healthcare Service Hotline for help.

What is Guarantee of Payment (GOP)?

- Guarantee of Payment (GOP) is an administrative arrangement service that FTLife provide to client, we will pay the approved amount for you to the designated healthcare service provider for the surgery/ hospital charges. Please note that this does not represent any finalized claims, FTLife reserve rights to claw back shortfall.

Can I use my usual doctor for the service?

- Current, clients of MediGold/ MediGold Plus/ MediPro/ MediChamp are eligible for using non-network doctor application to apply GOP service. While clients of other medical products are eligible for using Network doctors to apply GOP service.

When will the shortfall be collected and how?

- The estimated shortfall amount will be included in the result notification letter, normally, we will not charge the shortfall amount over the estimated amount. When the surgery/admission is done, once the medical invoice is received, claims team will settle the case calculate the actual shortfall, we will issue a Claim Settlement Advice to you and your agent to notify the upcoming charges of shortfall. We will charge the shortfall amount via the credit card provide by you during the application after 14 days of the Claim Settlement Advice letter date.

Can I use the network doctor as second claim?

- No, if GOP application is chose and procced, FTLife can only be your first claim insurer. If you wish to claim other insurer for GOP application case, please note that the case will be settled around 45 days after the surgery date/ date of discharge. You may wish to consult your other insurer for claims procedure beforehand.

Will I get settlement table after the surgery/hospitalization?

- We will issue settlement table on request bases. Cases with shortfall will always receive settlement table before we collect shortfall via credit card.

Medical - FAQ

What are the different types of medical/hospital benefits?

- Different medical/hospital products in each insurer may carry varying features, definitions and exclusions whilst benefits are payable upon hospitalization or receiving day surgery services in specified conditions
- In general, insurer may offer coverage for a variety of product types:

Hospital Income	• Pay a fixed amount for each day of hospitalization subject to specified benefit limits
Hospital Reimbursement	• In-patient or day surgery service • Benefit is to reimburse medical expenses actually incurred subject to specified benefit limits • Reimbursed amount no greater than actual expenses
Hospital Surgical Benefit	• Pay a fixed amount when a particular medical/surgical procedure is performed

- Some medical/hospital products may incorporate other specific features i.e. a small compassionate death benefit, medical evacuation services, panel network services, pre & post medical consultation benefits, pre-approval services, etc.

What is Voluntary Health Insurance Scheme (VHIS)?

- The Health Bureau of Hong Kong launched the Voluntary Health Insurance Scheme (VHIS) in April 2019. It aims to instigate minimum standards for individual medical insurance plans with greater transparency for an insured.
- Insurers participating in the VHIS (“VHIS Providers”) offer individual indemnity hospital insurance plans that are certified by the Health Bureau of Hong Kong to comply with the minimum requirements of the scheme in product design (“Certified Plans”).
- Moreover, VHIS Providers must comply with a set of Code of Practices covering sales and marketing, handling of applications, after-sales services, etc.
- For details, please refer to the Official Homepage of the Voluntary Health Insurance Scheme (VHIS) https://www.vhis.gov.hk/en/

What is 120 days exclusion clause for non-VHIS medical plans?

- Depending on the plans purchased, the "120 Days Clause" for non-VHIS medical benefit generally exclude treatment/ surgery for an illness primarily related to the specified organs: tonsils, adenoids, hernia, cataract, tonsils, adenoids, hernia, cataract, sinus related conditions, piles/ fissure/ fistula-in-ano/ rectal prolapse or a disease peculiar to the female generative organs.
- If treatment for an illness/condition affects the specified organs, it would fall under the exclusion as well.
- The 120 days counts backward from the earliest treatment/surgery date established in relation to the claimed illness. We shall look for when the treatment/surgery commence, not the hospitalization date or duration.

What is the meaning of Confinement?

- ‘Confinement’ for a medical/hospitalization insurance plan usually defines, any continuous period of hospitalization as an in-patient whilst ‘Per Confinement’ is the limit of coverage for each hospital admission.

- Depending on the non-VHIS medical plans purchased, multiple hospital admissions for the same medical condition or illness are still considered as a single confinement and classified under one policy limit, rather than multiple limits (called same confinement), unless such hospitalization is separated by more than 90 days from the date of discharge from hospital or the last consultation by the medical practitioner, whichever is the later.
  - Example: An insured is hospitalized for gastritis followed by another hospitalization for the same illness ten months later. The hospitalizations will be considered as different (not one and the same) confinement despite the same/related cause as long as they are separated by more than ninety days, from the date of discharge from hospital or the last consultation by the medical practitioner, whichever is the later.

- In some situations, it is quite challenging to establish whether the insured has been treated for the same injury/illness or for a related cause or complications within a separate hospitalization.
  - Example: An insured is admitted into hospital for a severe respiratory infection but after hospital discharge, he develops pneumonia. The question is whether the pneumonia is a related illness or a separate medical condition.

- The 'same confinement' basis is not applicable for VHIS medical plans.

What is the meaning of Reasonable and Customary?

- Depending on the medical plans purchased, the term 'Reasonable & Customary' is used to consider whether the fee charged by a particular type of medical practitioner is reasonable or not, within a geographical area.

- We will reference reasonable and customary charges with all of the following figures (if applicable) each associated with the location where treatment, procedures, supplies or other medical services are received:
  - (i) Local government published materials containing private patient service charges for local public hospitals (in Hong Kong, this means the Government Gazette of the Hong Kong Special Administrative Region); and
  - (ii) Statistics provided by local health authorities and data collected from local practicing specialists and surgeons; and
  - (iii) Investigations announced by local insurance regulatory authorities; and
  - (iv) Other categories of references applicable locally.

- Example: The insured, 45 years old, has experienced abdominal pain and change of bowel habit and needs to undergo day surgery for gastroscopy and colonoscopy. He visits a private doctor where he is advised that his surgery will cost him HKD 50,000. However, the reasonable charge for such day surgery shouldn't be more than HKD 28,000, based on the same procedure across multiple similar quality day surgery centres. In this case, the insurer may only make a reimbursement in line with the reasonable charge of HKD28,000 and the insured will be required to pay the balance of HKD 22,000 at his own cost.
  **The reasonable fee amount may change from time to time based on medical inflation and other conditions*

What would be considered medically necessary?

- means a hospitalization, treatment, procedure, supply or other medical service that:
  - (i) Necessary for diagnosis or direct treatment of the insured's illness or injury; and
  - (ii) appropriate in relation to the signs and symptoms of the insured's illness or injury; and
  - (iii) generally accepted by the medical profession in Hong Kong as effective, appropriate and necessary in accordance with recognized standards in the relevant health care field; and
  - (iv) is not experimental, preventive, screening or investigative in nature; and
  - (v) (For hospitalization only) the insured's illness or injury cannot be safely and adequately treated without hospitalization; and

- (vi) (For outpatient surgery only) the insured's illness or injury cannot be safely and adequately treated without surgery.

- Example: The insured (aged 20) complains of severe headaches and is admitted into hospital for multiple tests such as MRI, MRA Brain, nerve conduction study, laboratory tests, etc. The insured's hospitalization is two weeks following the medical consultation and the final diagnosis is 'conjunctivitis'. The insured's hospitalization is not considered 'medically necessary' due to:
  - There is no evidence that the insured's complaint is considered an emergency that requires urgent treatment in hospital;
  - No surgical procedures nor treatments performed;
  - The insured is not a high-risk patient with any complications, or of old age; and;
  - The respective medical tests could have been performed safely and adequately in an out-patient setting.

If I have received an operation in a clinic or in an out-patient department of a hospital, but my existing medical policy does not have the benefit of "out-patient surgery fee", am I eligible for the claim?

- Yes, "out-patient surgery fee" benefit applies to existing medical policies.

What is the fee for applying medical reports from public hospitals?

- Applying for medical reports: HKD695, applying for hospital discharge summary: HKD70.

If I have been hospitalized in a public hospital because of acute diseases or accident, what is the condition of waiving claim form Part II?

- Claim From Part II can be waived if the policy has been in force over one year, the duration of hospital benefit does not exceed 3 days and "Discharge Summary" from hospital can be submitted.

If the same doctor performs both anesthesia and operation for me, can I claim for the anesthesia fee?

- According to terms and conditions of the policy, the anesthetist cannot be the Medical Practitioner treating you. Under such circumstances, anesthesia fee will be counted in the surgery fee.

Any reference for Reasonable and Customary Charges?

• Generally, the surgical fees provided by the Hospital Authority are usually inconsistent with those in the private sector. The private sector may charge 1.5 times to 2 times or more, so we will make reasonable adjustments at different ward levels, such as 1.5x (half private room) and 1.9x (private room).

• We will also consider the severity of the patient's current and past medical conditions to make reasonable adjustments as this may lead to complications and the possibility of prolonging the operation time and thereby increasing the cost of the operation.

• Hospital Authority Private Medical Services: https://www3.ha.org.hk/fnc/Operations.aspx?lang=ENG

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VHIS – FAQ

What is the definition of "Hospital"?

- With effect from 1 Apr 2023, hospital shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which –
  - has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong) ;
  - provides twenty-four (24) hours nursing services by licensed or registered nurses;
  - has one (1) or more Registered Medical Practitioners; and
  - is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

What is the definition of value-added tax (“VAT”) and goods and services tax (“GST”)?

- VAT and GST shall mean value added taxes, goods and services taxes or other taxes, duties or levies of a similar nature, which may be charged or imposed by the relevant tax or similar authorities or governmental departments on the expenses incurred for Medical Services rendered with respect to a Disability.

Are VAT and GST levied on medical fees and expenses charged by the authorities in the locality where the medical service is rendered covered by VHIS?

- With effect from 1 Mar 2022, eligible Expenses shall include the VAT and GST (if any) charged or imposed on the expenses incurred for Medical Services rendered with respect to a Disability.
- Any VAT and GST which is refunded to the Policy Holder or Insured Person (as the case may be) shall not be recoverable under the Terms and Benefits.

How would the VAT and GST be payable?

- Where the VAT/GST is incurred on an itemised basis, the VAT/GST associated with a specific benefit item shall be counted towards the Eligible Expenses payable under that particular benefit item.
-
- Where the VAT/GST is incurred in a lump sum without itemised breakdown, such lump sum shall firstly be allocated to the relevant expense items on a pro-rata basis. This means that the portion of VAT/GST corresponding to expense items other than Eligible Expenses shall not be claimable. After that, the VAT/GST allocated to a particular Eligible Expense item shall be added to the expense of that item and then claimed against the corresponding benefit item of a VHIS Policy.

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Accidenity Indemnity & Personal Accident - FAQ

What are the different types of accident benefits?

- Accident benefits are titled with different names/packages in the insurance industry, and individual accident contracts may not carry identical features.

- Accident Benefits refer to a variety of insurance coverage for accidental events such as Accidental Death Benefit (ADB), Accidental Death and Dismemberment (ADD), Accidental Indemnity (AI) and Personal Accident (PA) benefits, etc.

- Major Accident Claim refers to the claiming for benefits from the insured/beneficiary for the major accident events. Such major accident events include:

  - Death and Dismemberment
  - Major Burn/Third Degree Burns
  - Broker Bone
  - Total and Permanent Disablement

- Depending on the plans purchased, benefits that to be claimed under Minor Accident Claim include:
  - Temporary Disablement (Temporary Total/Partial Disablement)
  - Double Indemnity
  - Medical Expenses
  - Hospital Indemnity/ Hospital Cash
  - Surgical Indemnity

What is an "Accident"?

- In general, the term "Accident" usually refers to an unfortunate event that is not expected.

What is the meaning of "directly and independently of all other causes"?

- "Directly and independently of all other causes" is a phrase that is common in an insurance contract for accident products. It aims to define the situations under which the insured is eligible for accident benefits.

- This phrase means that loss due to accident must be a result of "directly and independently of all other causes". In order for the accident to be covered by the insurance policy, it must be the sole cause of the injury, and no other contributing factors can be involved.

  - Example: If some diseases exist at the time of the injury, and such medical condition contributes to the loss, the loss may not be a result "independently of all other causes".

What is an Injury?

- In medical terms, an injury is defined as damage or harm caused to the body by an external force which may include physical wounds and broken bones, etc. Injuries can be classified into several types.
  - Example: blunt injury, penetrating trauma, explosive blast injury , burns and scalds etc.

- The severity of an injury can vary from minor to life-threatening, depending on certain factors such as the location and type of the injury, the extent of damage and the age and overall health of the insured. To define the severity of an injury, medical professionals usually perform a physical examination and may use diagnostic tests such as X-rays, CT scans, MRI, etc. to assess the extent of damage.

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- Most of our accident products specifically define the term "Injury" and reference to the term "Accident" in the insurance contracts, for example whether an injury was caused by an accident.

- Depending on the plans purchased, the term "Injury" sometimes defines the requirement for a visible sign of an injury (e.g. Accident Indemnity insurance contracts). On the other hand, some Personal Accident contracts do not insist on the external visible signs and define "injury" as an abnormal bodily condition caused directly and solely caused by an accident independent of all other causes.

- In general, an "Injury" NOT caused by "Accident" refers to injuries that are not the result of an unexpected or unintentional event. Examples:
    - Sunburn whilst sunbathing is generally not considered an accident as it is an expected consequence of prolonged exposure to the sun's UV rays.
    - If an insured intends to harm himself by drinking too much alcohol, this is not considered an accident.
    - Injuries that show signs of repeated abuse overtime, such as healing bruises, scars, or broken bones in various stages of healing.

What are external and/or visible injuries?

- Visible evidence for injury under an accident insurance policy (if applicable) refers to physical wound of an injury. This can be in the form of cuts, scrapes, scratches and punctured skin, etc. Examples:
    - Swelling
    - Wounds
    - Contusions/bruises
    - Lacerations
    - broken limbs/fracture
    - Even scratches
    - Scalds/burns

What is "Temporary Total Disablement"?

- Temporary Total Disablement (TTD) is a kind of coverage offered under some accident products providing financial support to the insured if they are temporarily unable to work due to injury.

- TTD benefits are typically limited to a specific period of time

- The insured is "temporarily total disabled" if the extent of injury is such that:
    - The insured is incapable of performing substantial and material duties of his/her occupation in the usual way, and such incapacity is continuous throughout the claim period, without interruption.

- Basically, we are considering the absence of working capability but not absence or reduction of income nor job availability.

What is "Temporary Partial Disablement"?

- Temporary Partial Disablement (TPD) is a kind of coverage offered under some accident products providing partial financial support to the insured if they suffer an injury that temporarily limits their ability to perform all the usual duties of their occupation.

- TPD benefits are typically limited to a specific period of time.

- For TPD, the extent of injury is of lesser extent such that the insured is only incapable of performing one or more of his occupational duties.

- The considerations would be the same as that for "Temporary Total Disablement".

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Disability - FAQ

What are the different types of disablement /disability (傷殘/傷病) benefits?

- Disablement/Disability benefits are named under different titles or packages in the insurance industry, and individual contracts may vary in the features. Basically, disablement/disability benefits are offered in the below main categories:

Lumpsum Payment Benefit	Lumpsum payment upon disablement/disability of the insured
Waiver of Premium (WP) Benefit	To waive premium upon Disability of the Insured
Payor Benefit (PB) at Disability	To waive premium upon Disability of the Policyholder/Payor
Total and Permanent Disablement under the Accident Indemnity Contract	Total and Permanent Disablement under the Personal Accident Contract

- Total and Permanent Disablement/Disability may be given different definitions in respective insurance contracts requiring a varying degree/extent of incapability within a certain period of time.

What is Total and Permanent Disablement/Disability?

- Total and Permanent Disablement/ Disability (TPD) is a type of disability insurance that provides benefits to the insured who becomes permanently disabled and unable to resume work.

- Depending on the benefits plans purchased, some insurance contracts may only cover disablement/disability resulting from an accidental injury, while others may cover disablement/disability caused by both accident and illness.

- Total and Permanent Disablement/ Disability may be given different definitions under their respective insurance contracts, requiring a varying extent of incapability within a specified period of time.

- Depending on the plans purchased, the occupation of the insured also plays an important role in determining the eligibility for total and permanent disablement/ disability benefits.

  - Examples:
    - the insured is incapable of performing “each and every duty of the insured’s regular occupation”, called ‘Own Occupation’;
    - the insured is unable to pursue his usual occupation, or any other similar occupation requiring similar skills, education, training and experience, called ‘Suited Occupation’; or
    - the insured is unable to perform “any occupation for profit, wage or compensation”, called ‘Any Occupation’

- The conclusion of “Disabled” or not may differ for two persons who have sustained the same nature and extent of severity because of their different occupations. However, some common factors are involved to determine if the insured meets the requirement of disablement/ disability:
  - The ability to substantially perform the duties of the insured’s previous or a similar occupation or business and to perform such adequately for a substantial period of time.
  - Whether the new/substitute occupation or business is comparable to the previous one, in respect of the insured’s education, training, experience and mental & physical capacities, and also in terms of earnings.
  - Other factors include the insured’s medical condition, age, functional limitations which include both physical and mental limitations, and activities of daily living.

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- In some products, a lumpsum payment will be paid if the insured is unable to perform some 'Activities of Daily Living', without assistance, as a result of an accident or disease. On the other hand, a lumpsum payment will be paid for some products where, if the insured has 'Presumptive Disability'.

- It is necessary to review the terms and conditions of the insurance contracts to understand the specific requirements and limitations of the total and permanent disablement/disability benefit.

What is "Own occupation"?

- "Own occupation" is a type of disability insurance that provides a benefit to the insured if he/she is incapable of performing "each and every duty of the insured's regular occupation". That is, no longer able to carry out the work he/she was qualified and hired to do
  - Example: For a lawyer who becomes disabled and can no longer practice law, an own occupation definition will still pay benefits even if he/she can still work in a related profession, such as teaching or consulting.

What is "Suited occupation"?

- "Suited occupation" is a type of disability insurance of which the coverage is based on the insured's ability to perform "any business for profit or wage for which the insured is fitted by reason of his education, training and experience".
  - Example: If a lawyer becomes disabled and unable to practice law, but can still undertake work in a related profession, such as teaching or consulting, he/she may not be considered disabled under terms of the suited occupation definition. The reason is that he/she may still be able to undertake work and earn an income in a related profession, even though he/she cannot practice law.

What is "Any occupation"?

- "Any occupation" is a type of disability insurance of which the coverage is based on the insured's ability to perform "any occupation for profit, wage or compensation."

- Under this definition, an insured is more difficult to claim benefits due to a disability because he/she must provide evidence that he/she will be unable to work for any occupation, not just his/her own
  - Example: If a lawyer becomes disabled and cannot practice law and also cannot work in a related profession, such as teaching or consulting, he/she will need to demonstrate that there are no jobs available given his/her functional limitations, skillset, and qualifications, or that he/she is unable to secure employment for any other reason.

What are 'Activities of Daily Living'?

- Depending on the plans purchased, 'Activities of daily living (ADLs)' refers to the basic self-care tasks that an insured must perform every day to meet their own personal needs such as washing, dressing, feeding, toileting, mobility and transferring.

- The level of independence in performing the Activities of Daily Living (ADLs) is taken into consideration when determining the type and an amount of coverage an insured may receive through disablement/disability products.

- Is there a minimum period for a condition to persist in order for it to be defined as a disability?

- The required length of time that a disablement/disability condition should last so as to meet the definition of total and permanent disablement/disability (TPD) varies according to the insurance contract's terms and conditions. The proof of loss such as medical conditions and occupation details for the subsequent functional limitation and occupation assessment are crucial to determine whether they meet the definition of TPD.

- The sick leave certificates issued by medical practitioners are a usual reference to determine the duration of disability. However, the medical criteria for sick leave may not always concur with the contract definition of disability. While determining the reasonableness of disability duration, we will consider:

  - Are there any objective tests (e.g. CT, X-ray, MRI, etc.) to offer a more definitive determination?
  - Is the recommended sick leaves/prognosis consistent with the diagnosis, medical care and treatment administered?
  - If the disability is long-lasting, is the insured receiving regular and on-going medical care and treatment?
  - What is the current activity and status of the insured? Has he resumed work and for how long? If so, does he work full-time/ part-time?

What is proof of continuing disablement/disability?

- Depending on the plans purchased, 'proof of continuous disablement/disability' refers to the supportive documentation that is required to be submitted to an insurer for on-going eligibility for benefits due to a disability. It also refers to the evidence that an insured provides to confirm that his/her disability has persisted or continued for a certain period of time.

- If the insured refuses or unable to submit proof of continuing disability, we may deny providing the disablement/disability benefit or terminate the on-going benefit.

- An insurer may require the insured to undergo an independent medical examination to assess the current status of disablement/disability.

What is 'Presumptive Disability'?

- Depending on the plans purchased, presumptive disability is a provision that allows the policyholder to receive insurance benefits if an insured suffers from a disablement/disability so severe that 'totally disabled' can be presumed.
  - Example: The occurrence of any of the following, to the insured shall also be considered as a disability:
    (i) the total and irrecoverable loss of sight of both eyes; or
    (ii) the complete and permanent paralysis of two limbs or actual severance at or above wrist or ankle of two limbs; or
    (iii) total and irrecoverable loss of the sight of one eye and either the complete and permanent paralysis of one limb or actual severance at or above wrist or ankle.

- This provision is designed to expedite the claims process and provide assistance to the insured who suffers from a severe medical condition.

Critical Illness - FAQ

What are Critical Illness benefits?

- There are different generations of Critical Illness contracts which vary in their coverage. Therefore, it is important to compare the different features and coverage offered by individual contracts.

- Critical Illness benefits are packaged with different product names in the market which may be offered in the following forms of benefit plans:
  - Accelerated Critical Illness benefit: It is a feature that allows the policyholder to receive a full or portion of the death benefit in advance if the insured is diagnosed with a critical illness. That is, an advance payment of the death benefit of the attached basic policy, provided that the insured is alive when he/she claims for the benefit.
  - Standalone Critical Illness benefit: It is a feature that provides coverage against specified critical illness. It pays a lump sum amount (not an advance payment of death benefit) upon the diagnosis of a covered critical illness without reducing the sum insured of the basic policy, provided that the insured is alive when he/she claims for the benefit.

- Early Critical Illness insurance product provides a limited or lump sum payment if the insured is diagnosed with early-stage critical illness. The claim payment is subject to a percentage of the sum insured which is based on the severity of the critical illness as defined in the benefit definition table

- Example: the early critical illness benefit may pay:
  1. 20% of the sum insured for the diagnosis of Carcinoma in Situ;
  2. 50% of the sum insured for Carcinoma in Situ of the Breast with Mastectomy; and
  3. 100% of the sum insured for Cancer.

- Tailor-made female critical illness product provides coverage for critical illness that is more prevalent with a woman. Apart from death and the usual critical illnesses, it covers illnesses such as:
  - Systemic Lupus Erythematosus (S.L.E.) With Lupus Nephritis Benefit
  - Carcinoma-in-situ of Breast or Cervix Uteri Benefit
  - Aplastic Anaemia Benefit
  - Congenital Anomalies Benefit
  - Complications of Pregnancy Benefit

- Multi-pay critical illness products provide multiple pay-outs if the insured suffers from more than one covered critical illnesses. The general features of this kind of policy includes:
  - Coverage continues after payment of the first critical illness claim
  - The Schedule of Living Benefit may be grouped under several categories and/or under different severity levels.
  - The contract wordings state the criteria/details of how a different and separate critical illness event will be payable such as the diagnosis dates, the remission periods and any specific provisions, etc.

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Death Benefit - FAQ

What is Death benefit?

- Death benefits are the basic benefit in life insurance policies. A variety of policies that provide death benefit include whole life, endowment, term plans, etc. The product range also varies across insurance industry.

- Generally, the products are classified into 2 main types:
- Natural Death:
  - Payment of benefit upon proof of death, whether it is natural or accidental death.
  - Most of the plans (i.e. whole life, endowment and term) provide coverage for natural and accidental death
- Accidental Death
  - Payment of benefit only on death caused by accident
  - Accidental death benefit is available under Accidental Death policy, Accidental Death and Dismemberment policy and Personal Accident policy.

How does a Death benefit operate?

- In general, while the policy is inforce, the sum insured is payable upon death or accidental death of the insured.

- Other Death-related benefits payable:
  - The Payor Benefit (PB): is a benefit to waive the premium for the death of the Policyholder/Payor.
  - Terminal Illness Benefit: Some products may include a Terminal Illness Benefit payable upon being diagnosed of Terminal Illness. The amount payable could be an accelerated payment of Death Benefit, depending on the plan features.
  - Compassionate Death Benefit: A small amount death benefit, usually available under both accident and medical policies.

What is proof of death?

- In general, proof of death in life insurance claim requires the submission of death certificate the insured, which is issued by a local authority stating the date and cause of death, to confirm the death of the insured person.

- To claim the death benefits, the burden of proof is on the claimant to provide sufficient evidence (e.g. death certificate) whereas:-

- For accidental death claim, the following documents/information may be required:
  - Date, time and location of the accident;
  - Name(s) and address(es) of any other injured person(s) or witness(es);
  - A copy of police or accident report that describes the circumstances of the accident.

- For non-accidental death claim, the following documents/information may be required:
  - Medical records (including the name and address of the insured's usual attending doctor(s) and consultation history);
  - Name, address and qualification of the doctor/person certifying the death of the insured.
  - Certificate of burial/cremation is usually required to proof the insured's death as this services as a confirmation that the insured has indeed passed away, along with:-
    - Full name of the deceased, date of death, and the location of burial/cremation;
    - Name(s) and address(es) of witness(es) of the burial/cremation (if any)
    - A coroner's report of post-mortem report may be required to for investigation, depending on the situations.
  - Examples:

- Sudden or unexplained death;
- Industrial accident;
- Homicides/murders;
- Medical malpractice

How to handle if the insured die overseas?

- When the claimant submits the death certificate (issued by local authority) of the insured person, we will process the claim as usual.

- However, the process time may be longer than usual because if the insured died in a place other than his/her home country, more information from the local authority where the insured died is required.

- If the body of the deceased is repatriated to his/her home country, the below information may help to rule out suspicious circumstances:
  - Details of the location and official who permitted the boarding of the deceased's body;
  - Police report and post-mortem report (if any) which may provide additional insights to the death of the insured;
  - Medical records if the insured had received medical treatments overseas for they can provide additional information about the insured's health condition.

What is presumptive death?

- "Presumptive Death" is a declaration made by a court of law for a person being missing and unaccounted for over a prolonged period of time (dependent on his/her country or region) and is presumed to be dead.
  - Examples:
    - Victims of kidnapping;
    - People who are involved in accidents at sea;
    - Aircraft accidents.
- When the presumptive death certificate is submitted by the claimant, we will process the claim assessment as usual.

- Many factors that may contribute to disappearance of a person such as accidents, intentional disappearance and foul play, etc.. It is necessary to investigate all possibilities before coming to the conclusion that the presumptive death is "natural" or "accidental".
  - Proof of death is of extreme importance and we should be attentive to the followings:
  - Evidence of any search effort;
  - Years of absence and cause of disappearance;
  - Proof of identity of the missing insured, and the relationship between the policyholder and beneficiary;
  - Policy reports with information about the date and location of the insured found missing;
  - Other information such as financial status of the missing insured, medical history of the missing insured;
  - Reappearance of the missing person.

What happens if an insured dies during the underwriting process?

- We should review the application date signed by the applicant and the payment date of the initial premium against the timeline of the event(s) causing the insured's death.

- As the probability of anti-selection and fraud for death claim is high during the underwriting process, it is necessary to have thorough review to rule out such possibility

- Does life insurance pay for death due to suicide within the first policy year?

- If the insured committed suicide within the first year of the issuance of his/her life insurance policy, most policies will pay out the death for suicide benefit just like any other cause of death.

- Paying suicidal death benefit is to follow the limited liability set forth in the Suicide Clause. Usually, the death benefit is the refund of premium, subject to the plan features.

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